SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

HOME AND COMMUNITY BASED WAIVER Policy Manual	Section: ADMINISTRATIVE REQUIREMENTS
	Subject: Provider Responsibilities

Reference: ARM 37.40.1407

GENERAL RULE All providers of Home and Community Based Services must:

1. Retain records, which fully disclose the extent and nature of services provided to members and which support fees charged or payments made;

2. Keep, establish and maintain accounting records that accurately identify, classify, and summarize all Medicaid funds and monies received disbursed by providing an adequate audit trail;

3. Accept Medicaid payment as payment in full and never charge member additional money unless it is to meet co-payments, incurment requirements, or for services not available under Medicaid;

4. Meet requirements of the Health Insurance Portability and Accountability Act (HIPAA);

5. Make Medicaid records available for audit or review by authorized state and federal staff;

6. Retain medical and financial records, supporting documents, and all other records supporting services provided for six years and three months. If any litigation, claim, or audit is started before the end of the sixth year and three month period, records must be retained until all litigation, claims or audit findings are resolved;

7. Be enrolled with XEROX as a Medicaid provider;

8. Document and verify Medicaid eligibility on a monthly basis;

9. File reports as required by the Department;

10. Complete the quality assurance process as required by the Department;

11. Provide a grievance procedure for members;

12. Submit Serious Occurrence Reports in a timely manner (refer to HCBS 609;

13. Report changes in provider contact information, addresses and telephone numbers in a timely manner to both the Department and XEROX;

14. Comply with all other policies and procedures as outlined in this manual and the Administrative Rules of Montana, and;

15. Specify and follow the standards of Principles of Charting:

    a) Record pertinent psychosocial and physical manifestations, incidents, any unusual occurrences or abnormal behavior;

    b) Chart facts, what is observed, heard, smelled, and touched. Document objective statements in the record. Avoid generalizations, vague comments and opinions;

    c) Document approaches used to correct problems identified in the members plan of care;

    d) Record all instruction given to the member and/or family;

    e) Include a statement when the member is admitted and when discharged from services; and

    f) Document the method of contact; e.g., telephone, home visit and the specific people included in the contact.